CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
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AFFIDAVIT OF INTERN EXPERIENCE

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who completed internship hours while employed in a pharmacy business.

- **The applicant completes the APPLICANT INFORMATION section and sends this form to his or her supervising pharmacist.**
- **The supervising pharmacist completes the remainder of the form, signs it in the presence of a notary and sends it *directly* to the Board office at the address above.**

APPLICANT INFORMATION

Name of Applicant: _____

INFORMATION ABOUT SUPERVISING PHARMACIST

1. Name of Supervising Pharmacist: _____
2. Delaware Pharmacist License Number: **A1 -** _____
3. Pharmacy Where Employed: _____
4. Pharmacy Address: _____

   _____ City _____ State _____ Zip
5. Delaware Pharmacy License Number: **A**___ - _____
6. Did you supervise the applicant above while he or she obtained professionally-oriented experience in the practice of pharmacy at the pharmacy entered above? Yes ☐ No ☐
7. Enter the following information about the hours of experience the applicant obtained under your supervision. ***If the applicant is a foreign pharmacy graduate, the hours entered must be after the date of FPGEC certification.***

START DATE	END DATE	HOURS
	TOTAL HOURS	

EVALUATION

8. The purpose of this evaluation is to alert the intern to weaknesses or any problem areas. Assess the applicant's professional development as demonstrated at the end of the experience period under your supervision. Using the Performance Criteria below, enter a grade for each of the nine areas of pharmacy practice. If any of these questions does not apply, refer to *Intern Performance Evaluation Comment Sheet*.

PERFORMANCE CRITERIA

A–Intern is able to perform this activity very effectively without supervision. Intern is fully prepared to assume this responsibility in practice.
B–Intern requires only occasional supervision to perform this activity effectively.
C–Intern is slow and/or requires frequent supervision to perform this activity. Intern needs additional experience to assume this responsibility in practice.
D–Intern makes significant mistakes on a regular basis, but may demonstrate an understanding of the concepts.
E–Intern is either unable to perform or insufficiently prepared to perform this activity.

1. Ability to apply knowledge of state and federal pharmacy law in the dispensing of medications:
   ☐ A ☐ B ☐ C ☐ D ☐ E
2. Ability to apply knowledge of Pharmacy Law in the acquisition (DEA order form) and distribution of controlled substances:
   ☐ A ☐ B ☐ C ☐ D ☐ E
3. Ability to dispense medications from prescription orders, including order interpretation, product selection, labeling and packaging:
   ☐ A ☐ B ☐ C ☐ D ☐ E
4. Ability to dispense (sterile & non-sterile) dosage forms requiring extemporaneous or bulk compounding:
   ☐ A ☐ B ☐ C ☐ D ☐ E
5. Ability to obtain and utilize patient-related information (i.e. patient profiles, interview, etc.) to insure patient safety and to minimize significant drug interactions and therapeutic incompatibilities:
   ☐ A ☐ B ☐ C ☐ D ☐ E
6. Ability to effectively consult with patients about their prescription drug therapy:
   ☐ A ☐ B ☐ C ☐ D ☐ E
7. Ability to perform basic triage functions with patients and to select and counsel patients on appropriate over-the-counter drugs or to refer patients to other health care providers (optional for Hospital Pharmacy Experience Externs/Interns):
   ☐ A ☐ B ☐ C ☐ D ☐ E
8. Ability to maintain pharmacy records, including DEA records, prescription files, patient profiles and counseling records:
   ☐ A ☐ B ☐ C ☐ D ☐ E
9. Ability to communicate with other health care professionals about patient therapy and/or drug information:
   ☐ A ☐ B ☐ C ☐ D ☐ E

AFFIDAVIT

I certify that I am a registered pharmacist in good standing, that I personally supervised the applicant above and I have accurately entered the applicant's professional assessment and recorded hours, to the best of my ability.

Signature of Supervising Pharmacist: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 11/2017

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INTERN PERFORMANCE EVALUATION COMMENT SHEET

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This form is for applicants for Delaware Pharmacist licensure who completed internship hours while employed in a pharmacy business. If evaluation of any performance statement in the EVALUATION section on the *Affidavit of Intern Experience* does not apply, the intern's supervising pharmacist completes this comment sheet to explain. For example, use this form to give an evaluation of the Intern's performance pertaining to experience in an alternate field of practice. The supervising pharmacist signs the form in the presence of a notary and sends it *directly* to the Board office at the address above.

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Signature of Supervising Pharmacist: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 11/2017